BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DIANTHA SUE SALOME** **2204 Palisade Avenue, Apartment 1** **Modesto, CA 95350** **Registered Nurse License No. 495423** Respondent.	Case No. 2012-665 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about April 27, 2012, Complainant Louise R. Bailey, M.Ed., RN, in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2012-665 against Diantha Sue Salome (Respondent) before the Board of Registered Nursing. (Accusation attached as Exhibit A.)

2. On or about August 31, 1993, the Board of Registered Nursing (Board) issued Registered Nurse License No. 495423 to Respondent. The Registered Nurse License was in full force and effect at all times relevant to the charges brought in Accusation No. 2012-665 and expired on October 31, 2010.

3. On or about April 27, 2012, Respondent was served by Certified and First Class Mail copies of the Accusation No. 2012-665, Statement to Respondent, Notice of Defense, Request for Discovery, and Discovery Statutes (Government Code sections 11507.5, 11507.6, and 11507.7) at Respondent's address of record which, pursuant to California Code of Regulations, title 16,

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section 1409.1, is required to be reported and maintained with the Board. Respondent's address of record was and is:

2204 Palisade Avenue, Apt. 1
Modesto, CA 95350

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c) and/or Business & Professions Code section 124.

5. On or about May 21, 2012 and May 29, 2012, the aforementioned documents were returned by the U.S. Postal Service marked "Attempted Not Known" and "Unclaimed." The address on the documents was the same as the address on file with the Board. Respondent failed to maintain an updated address with the Board and the Board has made attempts to serve the Respondent at the address on file. Respondent has not made herself available for service and therefore, has not availed herself of her right to file a notice of defense and appear at hearing.

6. Government Code section 11506 states, in pertinent part:

> (c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

7. Respondent failed to file a Notice of Defense within 15 days after service upon her of the Accusation, and therefore waived her right to a hearing on the merits of Accusation No. 2012-665.

8. California Government Code section 11520 states, in pertinent part:

> (a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

9. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on the relevant evidence contained in the Default Decision Evidence Packet in this matter, as well as taking official notice of all the investigatory reports, exhibits and statements contained therein on

file at the Board's offices regarding the allegations contained in Accusation No. 2012-665, finds that the charges and allegations in Accusation No. 2012-665, are separately and severally, found to be true and correct by clear and convincing evidence.

10. Taking official notice of its own internal records, pursuant to Business and Professions Code section 125.3, it is hereby determined that the reasonable costs for investigation and enforcement is $19,220.25 as of September 6, 2012, and the reasonable costs for the Attorney General prosecution is $6,967.50.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Diantha Sue Salome has subjected her Registered Nurse License No. 495423 to discipline.

2. The agency has jurisdiction to adjudicate this case by default.

3. The Board of Registered Nursing is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in the Accusation which are supported by the evidence contained in the Default Decision Evidence Packet in this case:

a. Respondent engaged in unprofessional conduct, as defined by Code section 2762, subdivision (e), in that in or about October 2007, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in the records of 12 patients at Memorial Medical Center pertaining to the controlled substances such as Dilaudid, morphine, Lortab, and Tylenol with Codeine #3, and dangerous drug Doxycycline. Respondent would frequently remove controlled substances for a patient without a physician's order, or in excess of a physician's order, sometimes making inconsistent or incomplete entries regarding the administration or wastage of the drug. On one occasion, Respondent removed a controlled substance for a patient a few minutes after the patient had been discharged.

b. Respondent engaged in unprofessional conduct, as defined by Code section 2762, subdivision (e), in that in during the months of February and March of 2008, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in the records of 8 patients at Doctors Hospital of Manteca pertaining to the controlled substance Dilaudid. Respondent would sometimes remove Dilaudid for a patient without a physician's order, and

would frequently make no entry or incomplete entries regarding the disposition of the drug.

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ORDER

IT IS SO ORDERED that Registered Nurse License No. 495423, heretofore issued to Respondent Diantha Sue Salome, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on MARCH 29, 2013.

It is so ORDERED MARCH 1, 2013

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

10919548.DOC
DOJ Matter ID: SA2010102485

Attachment:
Exhibit A: Accusation

Exhibit A

Accusation

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DIANTHA SUE SALOME** **2204 Palisade Avenue, Apartment 1** **Modesto, CA 95350** **Registered Nurse License No. 495423** Respondent.	Case No. 2012-665 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about August 31, 1993, the Board issued Registered Nurse License Number 495423 to Diantha Sue Salome ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and expired on October 31, 2010.

STATUTORY PROVISIONS

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

6. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct . . .

7. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
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> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> . . . .
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> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

8. Code section 4022 states:

> "Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:
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> (a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.
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> (b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a --------," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.
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> (c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

9. Health and Safety Code section 11173, subdivision (a), states, in pertinent part, that "[n]o person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge . . ."

COST RECOVERY

10. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES AND DANGEROUS DRUGS

11. "Dilaudid" , a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(J).

12. "Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(L).

13. "Lortab" is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(4).

14. "Doxycycline", an antibiotic, is a dangerous drug within the meaning of Code section 4211 in that it requires a prescription under federal law.

15. "Tylenol with codeine" or "Tylenol with Codeine #3", a combination drug containing 30 mg of codeine and acetaminophen, is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(2).

MEMORIAL MEDICAL CENTER

FIRST CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Record)

16. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that in or about October 2007, while on duty as a registered nurse in the

Emergency Department at Memorial Medical Center located in Modesto, California,[1] Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other records pertaining to the controlled substances Dilaudid, morphine, Lortab, and Tylenol with Codeine #3, and dangerous drug Doxycycline, as follows:

Patient B

a. On October 26, 2007, at 0401 hours, Respondent removed Dilaudid 4 mg from the Pyxis for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent made a "wastage" entry in the Pyxis ("Wasted from Station") at 0443 hours, indicating that 4 mg of Dilaudid was given to the patient, with the amount wasted listed as "0".

b. On October 26, 2007, at 0444 hours, Respondent removed Dilaudid 4 mg from the Pyxis for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent documented in the Pyxis at 0707 hours that she administered Dilaudid 2 mg to the patient and wasted the remaining 2 mg as witnessed by another nurse[2], but failed to chart the administration of the Dilaudid on the patient's Emergency Record and otherwise account for the disposition of the Dilaudid 2 mg.

Patient C

c. On October 28, 2007, at 0115 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart administration of the Dilaudid on the patient's Emergency Record, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg. Further, the patient had been discharged from the Emergency Department at 0103 hours.

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[1] Respondent was employed at the medical center from September 24, 2007, to November 12, 2007.

[2] The medical center's Policy and Procedure Manual for the Pyxis stated that two nurses were required to waste a controlled substance to document a witness for the wastage.

Patient D

d. On October 9, 2007, at 2018 hours, Respondent removed Dilaudid 4 mg from the Pyxis for the patient when, in fact, there was no physician's order authorizing the medication for the patient at that time.[3] Further, Respondent charted on the patient's Emergency Record that she administered Dilaudid 2 mg to the patient at 2105 hours, but failed to document the wastage of the remaining 2 mg of Dilaudid in the Pyxis and otherwise account for the disposition of the Dilaudid 2 mg.

e. On October 9, 2007, at 2117 hours, Respondent removed Dilaudid 4 mg from the Pyxis for the patient, charted on the patient's Emergency Record that she administered Dilaudid 3 mg to the patient at 2200 hours, but failed to document the wastage of the remaining 1 mg of Dilaudid in the Pyxis and otherwise account for the disposition of the Dilaudid 1 mg.

f. On October 10, 2007, at 0052 hours, Respondent removed Dilaudid 4 mg from the Pyxis for the patient, charted on the patient's Emergency Record that she administered Dilaudid 3 mg to the patient at 0055 hours, but failed to document the wastage of the remaining 1 mg of Dilaudid in the Pyxis and otherwise account for the disposition of the Dilaudid 1 mg.

Patient E

g. On October 25, 2007, at 2148 hours, Respondent removed morphine 15 mg from the Pyxis for the patient when, in fact, the physician's order called for the administration of only 8 mg of morphine for the patient. Further, Respondent charted on the patient's Emergency Record that she administered morphine 8 mg to the patient at 2155 hours, but failed to document the wastage of the remaining 7 mg of morphine in the Pyxis and otherwise account for the disposition of the morphine 7 mg.

h. On October 25, 2007, at 2234 hours, Respondent removed morphine 8 mg from the Pyxis for the patient, but failed to chart the administration of the morphine on the patient's Emergency Record, document the wastage of the morphine in the Pyxis, and otherwise account for the disposition of the morphine 8 mg.

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[3] The patient's physician issued an order for Dilaudid 2 to 4 mg by IV on October 9, 2007, at *2119* hours.

Patient G

i. On October 23, 2007, at 2103 hours, Respondent removed morphine 10 mg from the Pyxis when, in fact, the physician's order called for the administration of only 4 mg of morphine for the patient. Further, Respondent charted on the patient's Emergency Record at 2106 hours that the medication was held because the patient's pain was "controlled at present", but documented in the Pyxis at 2324 hours that she gave 6 mg of morphine to the patient and wasted the remaining 4 mg as witnessed by another nurse.

j. On October 23, 2007, at 1939 hours, Respondent removed Dilaudid 4 mg from the Pyxis for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent documented in the Pyxis at 1939 hours that she gave 2 mg of Dilaudid to the patient and wasted the remaining 2 mg as witnessed by another nurse, but failed to chart the administration of the Dilaudid on the patient's Emergency Record. In addition, Respondent made another entry in the Pyxis at 2324 hours that she wasted 2 mg of Dilaudid as witnessed by another nurse.

Patient H

k. On October 18, 2007, at 2129 hours, Respondent removed morphine 15 mg from the Pyxis for the patient when, in fact, the physician's order called for the administration of only 4 mg of morphine for the patient. Further, Respondent failed to chart the administration of the morphine on the patient's Emergency Record, document the wastage of the morphine in the Pyxis, and otherwise account for the disposition of the morphine 15 mg.

Patient K

l. On October 24, 2007, at 1936 hours, Respondent removed Dilaudid 4 mg from the Pyxis for the patient, documented in the Pyxis, at the same time, that she gave 1 mg of Dilaudid to the patient and wasted the remaining 3 mg as witnessed by another nurse, but failed to chart the administration of the Dilaudid on the patient's Emergency Record and otherwise account for the disposition of the 1 mg of Dilaudid. Further, at approximately 1945 hours, Respondent made an entry on the patient's Emergency Record, indicating that the physician had ordered Dilaudid 1 mg

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for the patient. At 1949 hours, Respondent canceled the entry, listing as the basis for the cancellation that the patient's symptoms had resolved.

Patient M

m. On October 9, 2007, at 2041 hours, Respondent removed two Lortab 7.5 mg tablets from the Pyxis for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Lortab on the patient's Emergency Record, document the wastage of the Lortab in the Pyxis, and otherwise account for the disposition of the two Lortab 7.5 mg tablets.

Patient O

n. On October 25, 2007, at 0533 hours, Respondent removed Doxycycline 100 mg from the Pyxis for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Doxycycline on the patient's Emergency Record, document the wastage of the Doxycycline in the Pyxis, and otherwise account for the disposition of the Doxycycline 100 mg.

o. On October 25, 2007, at 0533 hours, Respondent removed 2 tablets of Tylenol with Codeine #3 from the Pyxis for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Tylenol with Codeine #3 on the patient's Emergency Record, document the wastage of the Tylenol with Codeine #3 in the Pyxis, and otherwise account for the disposition of the 2 tablets of Tylenol with Codeine #3.

Patient R

p. On October 25, 2007, at 0356 hours, Respondent removed Lortab 7.5 mg from the Pyxis for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Lortab on the patient's Emergency Record, document the wastage of the Lortab in the Pyxis, and otherwise account for the disposition of the Lortab 7.5 mg.

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Patient S

q. On October 27, 2007, at 2152 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's Emergency Record, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg. Further, the patient was discharged from the Emergency Department at 2143 hours.

Patient T

r. On October 16, 2007, at 1915 hours, Respondent removed Dilaudid 4 mg from the Pyxis for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's Emergency Record, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 4 mg.

DOCTORS HOSPITAL OF MANTECA

SECOND CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

17. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that while on duty as a registered nurse in the Emergency Department at Doctors Hospital of Manteca located in Tenet, California,[4] Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other records pertaining to the controlled substance Dilaudid, as follows:

Patient 1

a. On February 19, 2008, at 1259 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, charted on the Patient Care Record that she administered Dilaudid 1 mg to

[4] Respondent was employed at the hospital from February 16, 2008, to March 20, 2008.

the patient at 1300 hours, but failed to document the wastage of the remaining 1 mg of Dilaudid in the Pyxis and otherwise account for the disposition of the Dilaudid 1 mg.

Patient 2

b. On February 20, 2008, at 0936 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, charted on the Patient Care Record that she administered Dilaudid 1 mg to the patient at 0950 hours, but failed to document the wastage of the remaining 1 mg of Dilaudid in the Pyxis and otherwise account for the disposition of the Dilaudid 1 mg.

c. On February 20, 2008, at 1046 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, charted on the Patient Care Record that she administered Dilaudid 1 mg to the patient at 1059 hours, but failed to document the wastage of the remaining 1 mg of Dilaudid in the Pyxis and otherwise account for the disposition of the Dilaudid 1 mg.

d. On February 20, 2008, at 1338 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient when, in fact, there was no physician's order authorizing the medication for the patient at that time. Further, Respondent documented in the Pyxis at 1338 hours that she gave Dilaudid .5 mg to the patient and wasted the remaining 1.5 mg, but failed to chart the administration of the Dilaudid on the Patient Care Record and otherwise account for the disposition of the Dilaudid 1.5 mg.

Patient 3

e. On February 25, 2008, at 0837 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the Patient Care Record, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

Patient 7

f. On March 6, 2008, at 0852 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, charted on the Patient Care Record that she administered Dilaudid 1 mg to the patient at 0855 hours, but failed to document the wastage of the remaining 1 mg of Dilaudid in the Pyxis and otherwise account for the disposition of the Dilaudid 1 mg.

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Patient 8

g. On March 7, 2008, at 1011 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the Patient Care Record, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

Patient 9

h. On March 7, 2008, at 1215 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the Patient Care Record, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

Patient 10

i. On March 7, 2008, at 1332 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the Patient Care Record, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

j. On March 7, 2008, at 1451 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient, but failed to chart the administration of the Dilaudid on the Patient Care Record, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

k. On March 7, 2008, at 1559 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient when, in fact, there was no physician's order authorizing the medication for the patient at that time. Further, Respondent failed to chart the administration of the Dilaudid on the Patient Care Record, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

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Patient 11

l. On March 8, 2008, at 0751 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient. At 0830 hours, a physician's order for Dilaudid 1 mg was entered on the Physician Order Sheet, but was crossed out by Respondent with a notation indicating that the patient had refused the medication. Further, Respondent failed to document the wastage of the Dilaudid in the Pyxis and otherwise account for the disposition of the Dilaudid 2 mg.

m. On March 8, 2008, at 0929 hours, Respondent removed Dilaudid 2 mg from the Pyxis for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the Patient Care Record, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 2 mg.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 495423, issued to Diantha Sue Salome;

2. Ordering Diantha Sue Salome to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: April 27, 2012

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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